The MDS Mentor

Cheryl Shiffer, BSN, RN, RAC-CT
MDS Clinical Coordinator
Andy Alegria
MDS Automation Coordinator

TEXAS Department of Aging and Disability Services

VOLUME 4, ISSUE 3 DECEMBER 2011

INSIDE THIS ISSUE:

1	Change of Therapy (COT) Clarifications
2	Change of Therapy (COT) Clarifications
2	End of Therapy (EOT) Clarifications
3	Early Discharges
3	Influenza Vaccine Coding
4	MDS News in Review
4	2012 April Item Set Updates to MDS 3.0
5	Contact Us and Useful Web Links

The MDS Mentor is published in March, June, September, and December each year.

ACRONYMS:

Assessment Reference Date (ARD)

Centers for Medicare and Medicaid Services (CMS)

CMS Long-Term Care Facility Resident Assessment Instrument User's Manual Version 3.0 (RAIM3)

Leave of Absence (LOA)

Minimum Data Set (MDS)

Omnibus Budget Reconciliation Act (OBRA)

Prospective Payment System (PPS)

Skilled Nursing Facility/ Nursing Facility (SNF/ NF)

Change of Therapy (COT) Clarifications (Continued on Page 2)

In order to understand and correctly complete a COT Other Medicare Required Assessment (OMRA) , it is essential to read Chapter 2 of the RAIM3 and both of the National Provider Call Follow-Up and Clarifications (NPCFUC) documents. The first NPCFUC document is dated 8/23/11, while the other is dated 11/3/11. Both documents can be accessed at http://www.cms.gov/SNFPPS/03_RUGIVEdu12.asp under "Downloads."

An essential point from the 8/23/11 NPCFUC document informs staff when a COT OMRA is required: "Day 7 of the COT observation period occurs 7 days following the ARD of the most recent PPS assessment used for payment, regardless if a LOA occurs at any point during the COT observation period." Guidance for billing is found on page 2-70 of the RAIM3, "the day preceding the midnight on which the resident was absent from the nursing home is not a covered Part A day." However, whether the days are billable or not, any days that the resident is on a LOA are still counted when determining the ARD for the COT because the COT ARD is determined using calendar days, not Medicare days.

For example, what if a resident had a 14-day scheduled PPS assessment ARD set on day 14, but was in the Emergency Department on a LOA at midnight on day 16 and was on a therapeutic LOA at midnight on day 20? If the requirements for completing a COT were met (e.g., the therapy Resource Utilization Group (RUG) changed categories), then the COT OMRA would have an ARD of 7 calendar days after the ARD of the 14 day PPS MDS, despite the fact that day 16 and day 20 would not be Medicare Part A billable days.

Another important point which both the RAIM3 and the 8/23/11 NPCFUC document note is a COT OMRA is correctly combined with a scheduled PPS assessment when all the following are true:

1. The ARD for the scheduled PPS assessment/COT OMRA is set for day 7 of the COT observation period.
2. Day 7 of the COT observation period is a valid ARD for the scheduled PPS assessment.
3. The requirements for a COT OMRA are met.

However, when facility staff elect not to combine the COT with the scheduled PPS MDS when a COT OMRA is due, and only complete the scheduled MDS alone with an ARD on or earlier than the date the COT was due, staff should monitor the resident's stay. Facility staff need to ensure at least one payment day based on the scheduled assessment occurs. If the resident is to be discharged on or before the first payment day of the scheduled PPS assessment, then the COT which was not completed becomes a required PPS assessment. The ARD for the COT, like all Medicare PPS MDS, must be set while the resident is still on Part A. Additionally, the ARD for the COT, like all unscheduled

Change of Therapy (COT) Clarifications (Continued from Page 1)

HELPFUL HINT:

When a resident is discharged and the correct date of discharge coded for Item A2000 is on or prior to Day 7 of the COT observation period, then no COT OMRA is required.

NPCFUC 11/3/11

PPS MDS, must be set no later than 14 days after the appropriate ARD for the COT.

A scheduled PPS MDS that has no payment days should not be completed or transmitted. If it is already transmitted, staff may inactivate it. Inactivation ensures the COT, if it has the same ARD as the scheduled PPS MDS , will be accepted by the CMS MDS database. As directed on page 2-71 of the RAIM3, once a resident is no longer on Medicare Part A (discharged from the facility, discharged from Part A but remains in the facility), staff can no longer set the ARD for any Medicare assessments, scheduled or unscheduled. So, if facility staff do not set an ARD for the COT prior to or when the resident is discharged, all the days of the COT observation period and until the resident is discharged off Part A become Medicare non-billable days.

To avoid the situation addressed in the previous two paragraphs, CMS staff recommend that facility staff combine the COT and the scheduled PPS MDS when the dates overlap.

End of Therapy (EOT) Clarifications

The RAIM3 and both of the 8/23/11 and the 11/3/11 NPCFUC documents also contain important information for scheduling and completing the EOT OMRA.

One educational item from the 11/3/11 NPCFUC document explains since an EOT OMRA is only required when the resident's MDS is classified into a Rehabilitation (Rehab) or Rehab plus Extensive Services RUG category, "an EOT OMRA is not necessary for residents who have not yet been classified into such a RUG category on a scheduled or unscheduled PPS MDS. Furthermore, for residents who do not receive therapy for three consecutive calendar days during the allowable ARD window for the 5-day scheduled PPS assessment, facilities are not required to adjust the date of the ARD for the 5-day assessment or to combine the 5-day assessment with an EOT OMRA."

Another important clarification from the 11/3/11 NPCFUC document is related to when a resident's MDS is classified into a Rehab or Rehab plus Extensive Services (ES) RUG category and the resident "does not receive any therapy services for three or more consecutive calendar days and the resident is discharged from the facility on the third day of missed therapy services, then no EOT OMRA is required." While the guidance provided is correct, it does not mean a resident can be maintained on Medicare Part A after all therapy has ended, when therapy was the only skilled service and the reason for the Medicare stay, for up to three days. When therapy is the only skilled service, CMS' expectation is discharge from all therapy and discharge from Medicare Part A will occur concurrently.

Finally, the 8/23/11 NPCFUC document explains that an End of Therapy with Resumption (EOT-R) is not a new assessment type. An EOT-R would be noted as an EOT in item A0310C on the MDS Item Set. An EOT-R simply refers to a subset of items on the EOT OMRA, specifically O0450A and O0450B, which allow staff to confirm that all therapy disciplines resumed at the previous level and the date of therapy regimen resumption. CMS staff warn not to transmit the EOT-R until sure the previous RUG level is met.

Early Discharges – Managing Their MDS Assessments

If a resident discharges one hour or one day after admission, does the facility have to complete any MDS records? If so, which ones and how? While most of the answers will depend on payer source and facility policy, this article addresses some possibilities.

For the purpose of this article, the term "resident" refers to an individual admitted to a nursing home or swing bed facility. If an individual does not complete the admission process, then no MDS records need to be completed. If an individual is admitted to a nursing home or swing bed and becomes a resident; then an entry tracking record and either a discharge assessment or a death in facility record are required, regardless of how long the resident stays.

For nursing homes, pages 2-17 to 2-18 of the RAIM3 note the following concerning comprehensive assessments:

- If a resident is discharged prior to the completion deadline for the assessment, completion of the assessment is not required. Whatever portions of the RAI that have been completed must be maintained in the resident's medical record. In closing the record, the nursing home should note why the RAI was not completed.
- If a resident dies prior to the completion deadline for the assessment, completion of the assessment is not required. Whatever portions of the RAI that have been completed must be maintained in the resident's medical record. In closing the record, the nursing home should note why the RAI was not completed.

However, to bill for Medicaid, the facility must complete an OBRA Admission assessment. To bill for Medicare Part A, the facility must complete a PPS 5-day assessment. An assessment completed for billing purposes might have incomplete data but it is still necessary for Medicaid or Medicare billing. Refer to the "The Use of Dashes in Completing the MDS 3.0 Assessment …" document on the CMS Training Materials website for more information on the use of dashes when a resident is discharged unexpectedly.

They may forget your name but they will never forget how you made them feel.
~ Maya Angelou

Nurses dispense comfort, compassion, and caring without even a prescription.
~ Val Saintsbury

Influenza Vaccine (item O0250) Coding

As states, including Texas, are in the midst of the annual influenza (flu) season, it is an opportune time to discuss the coding of item O0250 Influenza Vaccine. From page O-6, of the RAIM3, the Steps for Assessment for item O0250 are as follows:

1. Review the resident's medical record to determine whether an Influenza vaccine was received in the facility for this year's Influenza season. If vaccination status is unknown, proceed to the next step.
2. Ask the resident if he or she received an Influenza vaccine outside of the facility for this year's Influenza season. If vaccination status is still unknown, proceed to the next step.
3. If the resident is unable to answer, then ask the same question of the resident's responsible party/guardian or primary care physician. If vaccination status is still unknown, proceed to the next step.
4. If vaccination status cannot be determined, administer the vaccine to the resident according to standards of clinical practice.

One of the most commonly asked questions regarding item O0250 is when should staff stop coding the resident received the influenza vaccine in the facility for this year's flu season. The answer is staff do not stop coding whether the resident received the influenza vaccine for this year's flu season until the next year's flu season begins. For example, September 2010 and September 2011 are when Texas' flu season began last year and this year. A resident received the flu vaccine on 10/5/10. Every MDS with an ARD on or after 10/5/10 through 8/31/11 should indicate in O0250A that "yes", the resident received the flu vaccine for this year's flu season in the facility and should indicate in O0250B the date of 10/5/10, in the required format of 10-05-2010.

MDS News in Review

- On October 1, 2011, the newest version of MDS 3.0 (V1.00.6) Item Sets became effective for all MDS with an ARD on or after 10/1/2011.
- On October 5, 2011, the "DRAFT MDS 3.0 Technical QM User's Manual" was posted on the CMS MDS 3.0 Technical Information web page.
- On October 6, 2011, CMS posted an errata document called "MDS3 0_V1 07_Errata.pdf" to correct errors in Chapters 2, 3 (Section O), and 6 of the RAI Manual that was published in September 2011. Also on October 6, three new training videos were posted on the CMS MDS 3.0 Training Materials web page with the titles "Section V Care Area Assessment," "Process of Care Planning for Residents in Skilled Nursing Facilities," and "PASRR."
- On December 12, 2011, MDS 3.0 data submission specifications (V1.10.1) were posted on the CMS MDS 3.0 Technical Information web page which includes changes to MDS 3.0 that will be effective April 1, 2012. Also posted was Version 1.10.4 of the MDS 3.0 Item Sets that will be effective April 1, 2012. The updated MDS 3.0 RAI User's Manual has not yet been published.
- Starting 1/3/2012, all Texas facilities are expected to begin switching over their secure broadband connection for transmission of MDS records to Verizon from AT&T. **AT&T broadband connections to transmit MDS records will be cut off on 2/3/2012.** Without Verizon, staff will not be able to transmit MDS records.

2012 April Item Set Updates to MDS 3.0

The following instructions are for anyone who wants to start learning some of the changes to the MDS 3.0 Item Sets that that will be implemented in April 2012 but who is not inclined to sift through the MDS 3.0 Submission Specifications:

1. Go to http://www.cms.gov/NursingHomeQualityInits/30_NHQIMDS30TechnicalInformation.asp.
2. Click on "MDS 3.0 Item Subsets V1.10.3 for the April 1, 2012 Release."
3. Open "MDS 3.0 Item Subsets V1.10.3_Part 1_20110926."
4. Open "MDS3.0_Item_Changes_v1.10.3.pdf."

Tips:

- The main set of changes starts on page 2.
- Page 1 is updates to the main set of changes, so start on page 2, read to the end, then go back to page 1.
- It is easiest to track the changes by having a copy of the MDS 3.0 Item Subset titled All Item Listing against which to compare. The Discharge Item Subsets may also be helpful.

The following is a small subset of those changes, as examples to show you what the document contains:

- X0100 becomes A0050, but options stay the same.
- A0310G added: planned or unplanned discharge. A0310G is used in a few skip patterns.
- A1500 now required for all comprehensive OBRA records, not just Admissions. Skip pattern added to skip new A1510 unless A1500 = Yes.
- A1510 added: Serious mental illness, Mental Retardation, or Other related conditions.
- A1800 adds new option: 09. Long Term Care Hospital (LTCH).
- A2100 adds new option: 09. Long Term Care Hospital (LTCH).
- A large number of items have been removed from some or all Discharge assessments - Item Subsets: ND, NOD, NSD, SD, SOD, or SSD. Compare the old and new Discharge Item Subsets or read the "MDS30-ItemSubsetsforApril1-2012Release" for a list. For example B0200 is removed from all Discharge assessments but B0700 is only removed from specific ones.

Dashing through the snow, in a one horse open sleigh. COT evaluation, every seventh day.
End of Therapy, if three days have a lack … but EOT-R if, in five days, therapy is back.*

* Only if therapy resumes at the same level.

Cheryl Shiffer, BSN, RN, RAC-CT
MDS Clinical Coordinator
11307 Roszell Street, Room 1310
San Antonio, TX 78217
Mail Code: 279-4
Phone: 210.619.8010
Fax: 210.619.8100
(Shared Fax - Call First)

Andy Alegria
MDS Automation Coordinator
P.O. Box 149030
Austin, TX 78714-9030
Mail Code E-345
Phone: 512.438.2396
Fax: 512.438.4286
(Shared Fax - Call First)

Useful Web Links

DADS MDS Web Site: Texas MDS site for MDS policy, procedures, and clinical and technical information (including The MDS Mentor). http://www.dads.state.tx.us/providers/MDS/

Sign up for MDS Resource E-mail updates: Go to http://www.dads.state.tx.us/, click on the "E-mail updates" tab and follow the directions. The "DADS Texas Minimum Data Set (MDS) Resources" emails are the key line of communication for MDS updates and alerts to nursing home and swing bed facilities from the DADS MDS staff.

Centers for Medicare & Medicaid Services (CMS) MDS Web Site for MDS 3.0: MDS 3.0 Highlights, RAI Manual, Item Sets (forms), related MDS 3.0 materials, and a link to MDS 2.0.
http://www.cms.gov/NursingHomeQualityInits/25_NHQIMDS30.asp

QIES TECHNICAL SUPPORT OFFICE (QTSO): MDS 3.0/2.0, jRAVEN/RAVEN and AT&T Client Software information. Validation Report Messages, Guides, Training and DAVE/DAVE 2 Tip sheets.
https://www.qtso.com/

Quality Reporting System (QRS): DADS information site on Texas nursing homes.
http://facilityquality.dads.state.tx.us/

Nursing Home Compare: CMS site that compares nursing homes in a given area.
http://www.medicare.gov/NHCompare/Include/DataSection/Questions/SearchCriteria.asp

5 Star Technical Manual: Explains data used to create the 5 Star Report.
http://www.cms.gov/CertificationandComplianc/13_FSQRS.asp

This guidance is being provided on the published date of The MDS Mentor. The reader should be aware that guidance regarding topics in The MDS Mentor may be time-limited, and may be superseded by guidance published by CMS or DADS at a later date. It is each provider's responsibility to stay current with the latest CMS and DADS guidance.